

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/30/2011
NAME OF PROVIDER OR SUPPLIER CHURCHMAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 4949 OGLETOWN-STANTON ROAD NEWARK, DE 19713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from September 21, 2011 through September 30, 2011. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 88. The survey Stage 2 sample totaled thirty-three (33) residents.	F 000	F 159 1. Powers of Attorney (POA) for R27 and R79 were provided with written statements of account. In addition, R27's POA was provided written documentation of actions taken on behalf of the resident to bring the resident's account below the state's asset level for Medicaid eligibility. 2. All accounts for all residents deemed incompetent were reviewed. POAs and or court-appointed guardians were provided up-to-date written statements of account. No other accounts were found to approach or exceed the state's asset level for Medicaid eligibility.	12/05/2011	
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.	F 159	3. Upon receipt of quarterly statements of account, a review will be conducted to identify residents who have been deemed incompetent and who have had a court-appointed guardian and/or a POA. Written statements of account will be mailed to POAs and court-appointed guardians, as appropriate. Additionally, the Business Office Manager (BOM) will review on a monthly basis all accounts for Medicaid beneficiaries to identify residents at risk of exceeding the state's asset level for Medicaid eligibility. The BOM will provide to POAs and/or court-appointed guardians of those deemed incompetent written documentation/receipts detailing efforts to bring the resident's account below the state's asset level for Medicaid eligibility. 4. Accounts will be audited on a quarterly basis by the administrator/designee to ensure that written statements of account and documentation regarding efforts to bring resident accounts below the state's asset level for Medicaid are provided. Results will be reported quarterly in QA.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR

10/27/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	<p>Continued From page 1</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the residents' personal fund statements and staff interview, it was determined that the facility failed to provide quarterly statements to two residents' (R27 and R79) out of three sampled residents' family or responsible party of their personal fund status. Additionally, the facility failed to provide a written notice to one (R79) of three residents' responsible family party, when R79's personal fund balances were above the Medicaid eligibility limits, or over \$2000. Findings include:</p> <p>1. Review of Resident R27 and R79's 6/30/11 quarterly Resident Fund Management Service statements revealed that the residents' responsible party did not receive the quarterly</p>	F 159			

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F 159	<p>Continued From page 2</p> <p>statement, which indicated how the funds were utilized by R27 and R79 for the 2nd quarter of 2011 (or during the months of April 2011, May 2011, and June 2011).</p> <p>Review of facility procedures entitled, "Resident Funds" Section 7 indicated that, "every three months, the Center shall furnish a quarterly statement to the resident if he/she is alert and oriented", and "if the resident is not alert and oriented, the quarterly statements should be sent to the responsible party no later than the 15th of the following month". Review of Section 7.4 revealed that, "if a resident is not competent, the quarterly statements should be mailed to the appropriate party".</p> <p>In an interview with E7 (Business Office Director) on 9/26/11, she confirmed she did not send quarterly statements to R21 and R79's (or any other resident at the facility) responsible party or POA.</p> <p>2. Review of Resident R79's personal fund account statements revealed an amount of \$2317 in the account as of 9/26/11, up to \$4259 in June 2011, up to \$4549 in the account in July 2011, and had up to \$3081 in the account in August 2011. There was no evidence that the facility informed the residents' responsible party in writing that his or her funds were over the limit for SSI. R79's account was over the \$2000 limit to maintain Medicaid eligibility.</p> <p>Review of facility procedures entitled, "Residents Funds" Section 11, "Medicaid Eligibility Letters" revealed that, "in accordance with state regulations, all Medical Assistant residents must</p>	F 159			

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F 159	Continued From page 3 be notified monthly when they are within \$400 of the state's asset level for Medicare eligibility". In an interview with E7 on 9/26/11, she stated that although she had informed the resident's responsible party verbally that R79's funds were over \$2000, and was working on spending down the funds to allowable limits by Medicaid, she did not notify R79's family/responsible party in writing as required in the procedures. She stated that she was unaware of the procedure requirements and confirmed this finding.	F 159			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: cross refer F323 example #1, F279 Based on observation, record review and interview, it was determined that the facility failed to ensure that one (1) resident (R52) was free from physical restraints that were not required to treat the resident's medical symptoms. Findings include: The facility's policy entitled, " Use of Bed rails" was reviewed. 1. R52 had diagnoses that included left tibia/fibula (bones between the knee and ankle) fractures which were non-surgically repaired, left CVA (stroke) and Left hemiplegia (paralysis).	F 221	F 221 1. <input type="checkbox"/> R52 assessment of 9/28/2011 inaccurately coded. An addendum is in place correcting it. A physician's order has been corrected to include the medical symptom as well as the purpose of the side rails. Signed Informed consent which includes risks, benefits and alternatives, has been obtained from the patient and is in the chart. A care plan problem specific to her side rails is in place. 2. <input type="checkbox"/> All patients with side rails have been reviewed for the same issues and documentation added where needed. 3. <input type="checkbox"/> Licensed and certified nursing staff has been in serviced on the required documentation for side rail use. 4. <input type="checkbox"/> An audit will be conducted monthly to monitor for documentation requirements by the DON/designee. Results will be reported monthly until firm compliance is verified.		12/05/2011

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F 221	<p>Continued From page 4</p> <p>According to R52's Minimum Data Set (MDS) assessment, dated 9/15/11, she scored 13 out of 15 for her brief interview for mental status (BIMS). R52 was assessed as always incontinent of bladder and bowel. R52 needed extensive assistance of one person for bed mobility, personal hygiene/bathing and dressing, was totally dependent upon two persons for assistance for transfer to/from bed chair/wheelchair (used a mechanical lift) and did not ambulate. R52 had impairment (no muscle control) in range of motion (ROM) on the left upper and left lower extremities. She used an electric wheelchair as a mobility device. Bed rails (bilateral 1/2 side rails) were used daily at all times when in bed.</p> <p>Review of R52's medical record revealed the following: The facility's quarterly reassessment for R52's need to use bed rails, dated 9/7/11, indicated (R52) "expresses desire for side rails". This assessment failed to indicate that it was being used for "positioning and support and able to demonstrate and/or to assist self to supine or sitting/standing position and able to demonstrate". The Physician's order initiated on 4/07/10 and renewed on 8/29/11 stated: "2 upper side rails for turning and positioning." It did not reflect the facility's 9/7/11 quarterly reassessment for the bilateral 1/2 bed rails use. While the side rails may have been used to enable R52's turning and positioning the documentation failed to provide supporting evidence for the use of the side rails and the resident's medical symptom of hemiplegia.</p>	F 221			

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F 221	Continued From page 5 In addition, R2's medical record lack documented evidence of the following: that the resident was informed/explained the potential risks and benefits of using bed rails versus not using bed rails and the alternatives to bed rail use. Additionally, although a care plan was initiated on 4/9/2010, "Requires assistance for ADL care in (bathing, grooming, dressing, eating, bed mobility, transfer, locomotion, toileting) due to chronic disease compromising functional ability", the use of the side rails was not included in the interventions.	F 221			
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, facility procedure review, and resident and staff interviews, it was determined that the facility failed to ensure that one (1) resident (R75) out of 33 Stage 2 sampled residents received notice before the resident's roommate in the facility was changed five times during the period between March 2011 through August 2011. Findings include: Review of the facility's procedure, "Room Transfers" indicated that for a patient receiving a new roommate, the facility would provide as much notice as possible, notify of appropriate departments of the room change, and social	F 247	F 247 1. <input type="checkbox"/> R75 whose MDS indicates she has cognitive and memory impairment has been notified of a new roommate each time. However this has not been documented as such. The next roommate change will be documented. Patient has been in the same room since admission. 2. <input type="checkbox"/> All patients will continue to be notified of roommate changes. Documentation will include roommate as well as room changes. This documentation was initiated as soon as it was pointed out by the surveyor. 3. <input type="checkbox"/> Nursing has been in serviced on documentation of roommate changes as well as room changes. Social Service will check the Home Page for new admissions and room transfers and verify that documentation is in place. 4. <input type="checkbox"/> An audit of room changes and roommate changes will be done monthly by Social Service with the results reported monthly in QA.	12/05/2011	

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F 247	<p>Continued From page 6</p> <p>service would follow up with the patient and the roommate to see how they were adjusting. The procedure indicated that all room changes would be documented in a progress note and placed in the medical record.</p> <p>R75 was admitted to the facility on 8/6/10. R75's annual Minimum Data Set (MDS) assessment, dated 7/28/11, indicated R75's was alert and oriented times three with a BIMS(Brief Interview of Mental Status) of 11. Record review for R75 revealed that she had five roommate changes from March 2011 through August 2011.</p> <p>An interview with R75 on 9/21/11 confirmed that she had a few new roommates in the past nine months. In an interview with R75 on 9/29/11, she stated that she has had various roommates, but was not informed prior to their arrival. She stated she was not given notice ahead of time to plan for the move.</p> <p>Review of R75's clinical record, including social service notes and nursing notes, lacked documented evidence that this resident and/or family were given notice before a roommate change was done for any of the five most recent roommate moves.</p> <p>In an interview with E8 (Nurse) and E6 (Unit Manager, Nurse) on 9/26/11 about roommate changes at the facility, they confirmed that there was no documented evidence of the notification to the residents, although they do notify residents verbally prior to the move.</p> <p>E6 stated that they notify residents as soon as they know there would be a move and that timeframe could be a couple of hours or before</p>	F 247			

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F 247	Continued From page 7 the new resident comes in. In an interview with E9 (Social Services Director) on 9/26/11, she confirmed there was no documented evidence of the roommate changes for this resident and she did not get involved with changes of roommates prior to the move. In an interview with E2 (DON) on 9/26/11, she confirmed this finding.	F 247			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Cross-refer to F323 example 1, F221	F 279	1. <input type="checkbox"/> A care plan problem specific to side rail use has been added to R52's care plan. This problem includes the reason for side rails, interventions for monitoring and adjusting side rail use and informed consent. 2. <input type="checkbox"/> All other patients with side rails in use have had a specific side rail problem developed for their care plan. 3. <input type="checkbox"/> Licensed and certified staff have been in serviced on the use of side rails and the required documentation and informed consent. 4. <input type="checkbox"/> A random audit of the care plans of patients with side rails will be done monthly with the results reported in QA monthly x 3 or until verified that compliance is no longer an issue.	12/05/2011	

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F 279	<p>Continued From page 8</p> <p>Based on record review and interview, it was determined that the facility failed to ensure that a care plan was developed for one (1) resident (R52) out of 33 sampled and failed to use the results of this resident's bed rails' assessments to include measurable objectives and timetables to meet this resident's needs that were identified in the comprehensive assessment. Findings include:</p> <p>On 4/9/2010 the facility initiated a care plan, "Requires assistance for ADL care in (bathing, grooming, dressing, eating, bed mobility, transfer, locomotion, toileting) due to chronic disease compromising functional ability". The interventions were as follows:</p> <p>Monitor for pain or discomfort and medicate as appropriate Assure the resident's comfort and privacy Encourage resident participation while providing appropriate ADL Identify self and expected tasks prior to beginning care use simple concrete statements Facilitate daily routine and minimize variations Maintain good body alignment Monitor for SOB, fatigue and change of condition and adjust task accordingly</p> <p>This care plan failed to indicate the use of the bilateral 1/2 bed rails for turning and positioning. In addition, it lacked interventions including how to prevent risk for bodily injury which may result if part of the body is caught between the rails or between the rail and the mattress; to ensure proper placement or proper size of the mattress or mattress with foam edges to prevent the</p>	F 279			

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F 279	Continued From page 9 individual from getting caught between the mattress and the rail, to ensure that gaps between the mattress and the rails are reduced in accordance with the Facility's Policy on Bed rail/Safety tips.	F 279			
F 309 SS=D	In an interview with E2 (DON) on 9/30/2011, she acknowledged this finding. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for 2 (R100 and R166) out of 33 Stage II residents. For R166 and R100, the facility failed to accurately monitor the residents' bowel movements and record review lacked evidence that the facility bowel protocol was followed. Additionally, the facility failed to follow R166's physician order for the rate at which oxygen was administered. Findings include: The facility's bowel protocol was reviewed which	F 309	F309 1. <input type="checkbox"/> R166 was examined by a physician with negative findings. The oxygen was adjusted down to the prescribed liter flow. R 100 had moved her bowels and documentation was corrected. 2. <input type="checkbox"/> Bowel records were reviewed on all patients and adjustments made as indicated. Oxygen orders and liter flow were verified on all patients receiving oxygen. 3. <input type="checkbox"/> Licensed and certified staff was in serviced on the bowel protocol and oxygen documentation. 4. <input type="checkbox"/> A random audit of bowel records and oxygen flow/orders will be done by the DON/designee monthly x3 or until compliance is verified.	12/05/2011	

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F 309	<p>Continued From page 10</p> <p>included, "9 zeroes = MOM (Milk of Magnesia) or an alternative order by MD; 12 zeroes = Suppository or an alternative order by MD; 15 zeroes = Fleet's Enemas & call MD after enema or alternative order by MD. CNA's will chart the BM's (bowel movements) by 1 hour prior to the end of their shift. Chart will be checked by supervisor for completion. When completed, supervisor will initial as indicated. Oncoming nurse will check chart & measure appropriately for consecutive zeroes. Nurse will mark the chart with the intervention used."</p> <p>1A. R166 was admitted to the facility on 9/16/11 with end stage cardiomyopathy (heart muscle disease), cardiac cachexia (loss of body mass that cannot be reversed), hypertension and status post nausea and irretractable vomiting with recent gastrointestinal bleed. R166 was admitted with hospice services. Per the meal percentage consumption sheets, R 166 consumed 0 - 25 % per meal from 9/16/11 - 9/29/11.</p> <p>R166's Admission Minimum Data Set (MDS) assessment, dated 9/24/11, coded bed mobility as extensive assistance with assist of 2, transfer as extensive assistance with assist of 1, toileting as dependent with assist of 1 and bowel as occasionally incontinent. The prognosis was coded less than 6 months and Hospice services prior to and since admission.</p> <p>The care plan, "Resident has expressed desire for palliative/comfort care related to terminal illness - end stage cardiomyopathy" was developed on 9/21/11. Interventions included collaboration with the hospice program to coordinate services as indicated and desired,</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085025	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/30/2011
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F 309	<p>Continued From page 11 establish bowel regimen and monitor ...</p> <p>Review of the ADL (Activities of Daily Living) Flow Sheet for September 2011 revealed that there were zeroes or there were blanks regarding size or consistency of BMs which indicated that R166 had no bowel movements for 11 days, from admission on 9/16/11 until 9/26/11. The blanks for size and consistency occurred 5 times during the day or evening shifts. Additionally, once during day shift and three times on evening shift, R166 was coded as being incontinent but then was listed as "0" for size and consistency. On 9/26/11, R 166 was noted to have been incontinent of a small formed BM and on 9/27/11 was incontinent of a small BM with "0" for consistency recorded.</p> <p>On 9/29/11, E4 (RN staff development) reviewed the hospital records in order to determine when R166 had a BM in the hospital prior to her admission to the facility on 9/16/11. E4 stated that R166 had a "good BM" noted on 9/9/11. E4 was unable to determine any BMs after 9/9/11 in the hospital records. E4 confirmed that the facility failed to monitor and failed to contact the physician to obtain an order for MOM or an alternative treatment as per the bowel protocol.</p> <p>Review of progress notes/ physician orders for R166 revealed that the notes did not address lack of BMs through 9/26/11. On 9/26/11, R166's physician ordered Senna S one tablet twice a day for constipation. On 9/30/11, at 7:45 AM E6 (RN UM) wrote a note which contradicted the ADL flow sheet for September 2011, "Resident noted with Med. (medium) soft stool this a.m. during application of Clobetial as is her usual pattern.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 12</p> <p>This Nurse notes a soft, small to med. stool almost daily since admission during treatments".</p> <p>In an interview on 9/29/11, E4 and E6 confirmed that there was a problem with the CNA's properly recording BMs for R166 and other residents. Also, E4 and E6 were unable to state why the nurses did not address the blanks and inconsistencies with the CNAs each shift and why after 9 zeros (3 days) the nurses did not initiate the bowel protocol.</p> <p>On 9/30/11, R166's physician examined the resident and noted that there was soft stool present in the rectum and no impaction. The assessment was that the bowel function was normal.</p> <p>On 9/30/11, in an interview with R166's physician regarding the bowel tracking, he stated that R166 did not have a fecal impaction based upon his examination. Additionally, he went through the communication book and stated that there had been no communication from nursing regarding concern for the lack of BMs for R166.</p> <p>The facility's system failed to accurately monitor BMs for R166. The facility also failed to follow their bowel protocol system for R166. On 9/30/11, findings were confirmed by E2 (DON).</p> <p>1B. On admission R166's physician ordered oxygen at 2 liters/minute for shortness of breath as needed. In the afternoon of 9/29/11, an observation was made of R166's oxygen running at @ 3 liters/minute. R166 did not appear to be in distress during observations on 9/27/11 and 9/29/11.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 13</p> <p>On 9/29/11 at 2:20 PM E4 went to R166's room with the surveyor and confirmed that the oxygen was incorrectly set @ 3 liters/ minute. E4 then set the oxygen to 2 liters/minute as ordered.</p> <p>Additionally, review of the Nurses notes revealed oxygen being incorrectly administered at 3 liters/minute on the following dates: On 9/22/11, E17 (LPN) documented that R166 had "Oxygen on 3l/min (liters/minute) continuous..." On 9/28/11, E17 documented that R166 had, "...Oxygen on at 3 l/min".</p> <p>The facility failed to administer oxygen at the level ordered by R166's physician. On 9/29/11, findings were confirmed by E2, E4 and E6.</p> <p>2. R100 was admitted to the facility in September 2009 and had diagnoses of atrial fibrillation, major depression, and muscle weakness.</p> <p>The annual MDS assessment, dated 8/25/11, coded R100 as alert and oriented. R100's functional status for transfer was coded as supervision with set up help only and for toilet use was coded as independent with no set up or physical help. Both bowel and bladder were coded as always continent for R100.</p> <p>The care plan entitled, "Resident exhibits or is at risk for gastrointestinal symptoms or complications related to constipated", last reviewed 8/30/11, had interventions of monitor and record bowel movements, provide bowel regime and assess for signs and symptoms of constipation.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 309	Continued From page 14 Review of the ADL flow record for September 2011, revealed that R100 had zeroes for BMs for 8 days from 9/21/11 through 9/28/11. Review of R100's physician orders, revealed that the resident was on Senna S and Miralax which are medications for constipation. Additionally on 9/8/11, R100 had MOM for constipation. On 9/27/11, E16 (LPN), stated that staff may not always be aware if R100 has moved her bowels since the resident is often independent with toileting. E16 went to R100's room and asked her when she moved her bowels last and R100 stated that it was 2 days ago. However, the ADL flow record did not revealed the BM 2 days ago. Additionally, review of the progress notes, failed to note any issues with bowel movements or need to initiate the bowel protocol. The facility's system failed to accurately monitor BMs for R100. The facility also failed to follow their bowel protocol system for R100. On 9/27/11 in an interview, E16 confirmed the findings.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	F 323 1. <input type="checkbox"/> The mattress of R52 was centered on the bed. The mattresses are made to fully fit the bed and rated for 300#. There was no gap when the mattress was centered and the patient turned to either side. The housekeeping cart was locked immediately upon notification. 2. <input type="checkbox"/> All beds were audited for proper position of the mattress and adjustments made as indicated. Doors to the supply rooms and soiled utility rooms were checked for auto closure and repaired as indicated by Maintenance. An audit of housekeeping carts was conducted; no other carts were found to be unlocked.		12/05/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 15</p> <p>Cross refer F221, F279</p> <p>Based on observation, record review and interview, it was determined that the facility failed to ensure that one (1) resident's (R52) environment out of 33 sampled remained as free from accident hazard as was possible. R52's mattress was off center on the bed frame and created an approximately 1 1/2 inch gap between the mattress and the bed rail on the left hand side of the bed. R52 was turned by the treatment nurse to her left side for treatment and dressing change of an "abrasion" on R52's right buttock. R52's left hand (without muscle control) got caught sideways between the mattress and the bed rail, unnoticed by the treatment nurse. This situation placed R52 at risks for injury although there was no injury sustained. Additionally, the facility failed to maintain the environment free from accidents hazards, as evidenced by an accessible and unlocked cleaning cart, unlocked supply room, and an unlocked soiled utility room on the West wing. Findings include:</p> <p>The facility's policy entitled, " Use of Bed rails" was reviewed.</p> <p>1. R52 had diagnoses that included left tibia/fibula (bones between the knee and ankle) fractures which were non-surgically repaired, left CVA (stroke) and Left hemiplegia (paralysis). According to R52's Minimum Data Set (MDS) assessment, dated 9/15/11, she scored 13 out of 15 for her brief interview for mental status (BIMS). R52 was assessed as always incontinent of bladder and bowel. R52 needed extensive assistance of one person assistance for bed mobility, personal hygiene/bathing and dressing, was totally dependent upon two persons for</p>	F 323	<p>3. <input type="checkbox"/> Certified staff, Environmental Services and Maintenance managers have been in serviced to check the mattresses to be sure that they are centered, to check the doors to the above referenced rooms to be sure they are closing properly, and to be sure housekeeping carts are properly locked.</p> <p>4. <input type="checkbox"/> A random audit will be done monthly by the Maintenance Department to verify mattress placement and door closing. Additionally, the Environmental Services Director will conduct random audits of housekeeping carts to ensure they are properly locked. Results of these audits will be reported by the department managers in QA monthly x 3 and will resume when problematic.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 16</p> <p>assistance with transfer to/from bed chair/wheelchair (used a mechanical lift) and did not ambulate. R52 had impairment (no muscle control) in range of motion (ROM) on the left upper and left lower extremities. She used an electric wheelchair as a mobility device. Bed rails (bilateral 1/2 side rails) were used daily at all times when in bed.</p> <p>Observation of a right buttock wound dressing changed on 9/27/11 at approximately 2:45 PM revealed the following: R52 was lying supine in her bed. R52 was unable to move her left hand and left leg (lack of muscle control due to CVA (stroke) plus fracture of the tibia and fibula on the left leg. E5 (RN) assisted R52 to turn on her left side and cued this resident to grab the bed rail with her right hand for support. It was observed by the surveyor that R52's left hand was caught sideways in an approximately 1 1/2inch gap between the mattress and the bed rail on the left hand side of the bed. R52 was not aware of it and E5 stated that she did not see it. However, after R52 was returned to a supine position, E5 observed that the resident's mattress was in an off centered position from the bed frame which created the gap between the mattress and the bed rail. E5 (RN) pulled and centered the mattress to the center of the bed thereby reducing the gap. E5 then elevated R52's left hand on a pillow that she placed against the bed rail. No injury was sustained to R52's left hand/arm.</p> <p>However, R52 was a high risk for entrapment due to her pre-existing condition and lack of muscle control on both left upper and lower extremities. The gap was created either by improper</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 17</p> <p>placement of the mattress and/or the movement and compression of the mattress caused by resident's weight of 190 lbs with a height of 62" per the MDS assessment, dated 9/7/11.</p> <p>On 9/29/11 during a bed bath/incontinence care observation, E15 (CNA) assisted R52 to turn on her left side so she could grab the bar with her right hand for support. R52 could not perform the same when turned on her right side due to left hemiplegia. The staff used the bed rails to aid them in turning and positioning this resident during her care. R52's bilateral 1/2 bed rails were always left in an upright position at all times when she was in bed. However, it was observed that R52 was unable to demonstrate the ability to assist herself using her right hand to sit and reposition herself using the side rails for support. R52 complained that her right shoulder also hurt when she tried to change positions by herself in bed.</p> <p>According to the FDA (Food and Drug Administration) Safety Alert: Entrapment Hazards with Hospital Bed Side Rails, "Patient's at high risk for entrapment include those with pre-existing conditions such aslack of muscle control..."</p> <p>An interview with E2 (DON) on 9/30/11@ 10:00 AM, acknowledged this finding.</p> <p>2. An observation was made on 9/27/11 at 11:00 AM of the facility's West wing hallway which revealed an open, unlocked cleaning cart that was unattended with chemicals that were accessible to residents and visitors. In an interview with E10 (Housekeeping staff) on</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 18 9/27/11, she stated she forgot to lock the cart and was observed with the key to the cleaning cart in her pocket. On 9/29/11, E12 (Director of Environmental Services) provided a copy of the in-service given to all housekeeping staff on locking the cleaning carts. 3. An observation was made on 9/27/11 at 11:00 AM of the West wing soiled utility room revealed the door to this room was unlocked. The room stored empty rollable and opened soiled linen carts accessible to the residents which posed a fall hazard to the residents. In an interview with E11 (CNA/Certified Nursing Aide) on 9/27/11, she confirmed this door needed to be kept locked and she stated the door did not close due to the latch not working properly. E11 proceeded to shut and lock the door. On 9/27/11 at 1:30 PM, the soiled utility door was again found unlocked. 4. An observation made on 9/27/11 at 11:05 AM revealed a supply room door on the West wing unlocked with contents accessible to residents and visitors. The room stored items such as a large opened box of razors, skin cleansers and other supplies. In an interview with E11(CNA) on 9/27/11, she confirmed the door was unlocked and needed to be locked. She proceeded to lock the room. When the surveyor asked if there were residents that could potentially wander from room to room, E11 confirmed that there was one resident (R103) that wandered from room to room and confirmed this finding.	F 323			
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372	F-372 1. <input type="checkbox"/> All trash was removed from the dumpster area and placed in the dumpster. The doors to the dumpster were closed 2. <input type="checkbox"/> All other dumpsters and exterior refuse containers were examined and found to be properly sealed		12/05/2011

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F 372	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations of the dumpster area during the tour of the dietary area, and staff interviews, it was determined that the facility failed to keep the dumpster, storing garbage and refuse, tightly covered to prevent pest harborage for three of six dumpsters on 9/21/11 and one of three dumpsters on 9/29/11. Findings include: Observations on 9/21/11 at 7:05 AM of the dumpster area outside the kitchen with E13 (Assistant Food Services Director) revealed three refuse dumpsters (of six) with either the side doors opened, a garbage bag of adult pads on top of one dumpster, and a leaky garbage bag resting on the door of one dumpster. Numerous small flies (gnats) were observed feeding from the leaky bag resting on the one dumpster. The three dumpsters were not tightly closed to prevent harborage of pests. On 9/21/11, an interview with E13 confirmed this finding. On 9/29/11 at 2:30 PM, one (out of three) dumpsters containing refuse had one side door opened and the contents were accessible to pests. On 9/29/11, E14 (Food Services Director) confirmed this finding.	F 372	3. <input type="checkbox"/> Signage will be placed on all dumpsters reminding staff to close all dumpster doors when disposing of refuse. A refuse disposal checklist will be posted at the rear exit. Staff shall document on the checklist the date and time each time they dispose of waste in the dumpster. 4. <input type="checkbox"/> Random audits of the checklist and dumpster area will be conducted by the Food Service Director. The Food Service Director shall report the results of these audits to the Administrator and QA committee monthly x 3 and resume when problematic. The QA committee shall assess and evaluate the data and provide recommendations as necessary to obtain and maintain compliance.		



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY: Churchman Village

DATE SURVEY COMPLETED: September 30, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>An unannounced annual survey was conducted at this facility from September 21, 2011 through September 30, 2011. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 88. The survey Stage 2 sample totaled thirty-three (33) residents.</p>	
3201	<p>Regulations for Skilled and Intermediate Nursing Facilities</p>	
3021.1.0	<p>Scope</p>	<p>Please refer to CMS 2567 survey reported dated 09/30/2011.</p>
3201.1.2	<p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey report date completed 09/30/11, F159, F221, F247, F279, F309, F323 and F372.</p>	<p>Substantial compliance on or before 12/05/2011</p>

Dean C. Reid 10/27/2011
DEAN C. REID, NHA